JMU-OTCES Clinical Case History Form

This information will provide important information for our therapists to assist in the evaluation and treatment of your child. Please fill out this form as completely as possible.
Thank you for your assistance!

I. Client Information

Name:_____ Age:_____
Address:_____ Date of Birth:_____
_____
Client lives with:_____

II. Family Information

Parent
Name:_____
Profession:_____
Address: *same as above*
_____
_____
home phone:_____
work phone:_____
cell phone:_____
e-mail address:_____
best way to contact you:_____

Parent ☐non applicable
Name:_____
Profession:_____
Address: *same as above*
_____
_____
home phone:_____
work phone:_____
cell phone:_____
e-mail address:_____
best way to contact you:_____

III. Sibling Information

Name of Sibling	Age	Any Related Difficulties

IV. Birth History

Medications taken during pregnancy or labor:
_____

Labor: ☐normal ☐induced ☐c-section
Birthplace:_____
Birth Weight:_____ Full Term Birth? Yes No _____
Length of Labor:_____ Length of Hospital Stay: _____
Check any that apply:
☐Bed rest during pregnancy ☐required oxygen at birth ☐jaundice
☐Allergies ☐poor sucking ability ☐poor weight gain ☐colic

V. Current Medical Information

Pediatrician Name:
Address:
Phone Number:

Date of Last…	Results	Additional Notes
Physical		
Hearing screening		
Vision screening		

Diagnoses: _____
Allergies: _____
Current Medications: _____
Hospitalizations: _____
Dietary Restrictions: _____

VI. Gross Motor Development

Please note when your child was able to:

Skill	Date
Roll over	
Sit independently	
Crawl	
Walk	
Run	

Does your child (check if applicable)

- ☐Appear uncoordinated or clumsy
- ☐Have difficulty using playground equipment
- ☐Have difficulty using playground equipment
- ☐Bump into objects or people when walking
- ☐Have difficulty riding a bike

VII. Language and Auditory Memory

At what age did your child develop language? (1 word or simple phrases)_____

Does your child:

- ☐Have difficulty articulating when talking
- ☐Have difficulty following simple or multi-step instructions
- ☐Require additional time to process information
- ☐Visually watch others for cues to know how to respond

VIII. Visual-Perceptual Skills

Does your child:

- ☐Visually track a moving object
- ☐Have difficulty identifying background from foreground
- ☐Have poor line orientation or spacing when writing
- ☐Prefer to print
- ☐Mix letter cases when writing
- ☐Write slowly

IX. Fine Motor Development

At what age did your child establish hand dominance? ☐Left ☐Right

Does your child:

- ☐Participate in constructional building activities
- ☐Have difficulty grasping and manipulating small objects
- ☐Have difficulty completing tasks that require both hands working together (i.e. stringing beads)
- ☐Have difficulty using scissors
- ☐Create immature drawings compared to other children of the same age
- ☐Have difficulty using eating utensils correctly

X. Self-Help Skills

A. **Feeding**

Was your child: ☐breast fed ☐bottle fed

Please note when your child was able to:

Skill	Date
Drink from a cup independently	
Feed self with fingers	
Use a spoon	
Use a fork to stab food	

Does your child have any difficulties with eating, drinking or using utensils?

_____

Food allergies: _____

B. Toileting

Age toilet trained (please note any problems with toilet training):

_____

Does your child have any constipation issues? _____

C. Dressing

Please check skill level:

Task	Performs Independently	Performs with Assistance
Puts shirt on and takes it off		
Puts pants on and takes them off		
Puts shoes on and takes them off		
Buttons pants/shirts		
Zips/unzips jacket		
Orients clothing correctly on body		
Ties shoes		
Uses a tissue when blowing nose		
Washes hands		
Uses restroom		

Any sleep difficulties?:_____

XI. Psychological and Neurological Development

Has your child had a psychological assessment ☐yes ☐no
If yes:
Reason for Assessment: _____
Date: _____
Location: _____
Summary of Results:
_____
_____

Has your child had a neurological assessment ☐yes ☐no
If yes:
Reason for Assessment: _____
Date: _____
Location: _____
Summary of Results:
_____
_____

Do you have any concerns related to peer relationships/friendships? If so, please describe:
_____

Does your child:
☐become easily frustrated ☐have outbursts of uncontrolled behavior
☐do better with a structured routine ☐have difficulty with organizational skills
☐have difficulty following instructions or rules
☐need to change activities frequently, or do something that someone else is doing
☐have difficulty taking turns with others
☐have difficulty forming relationships, making friends, or being accepted by peers
☐complain of physical problems ☐have immature social interests
☐try to control situations ☐need immediate gratification

XII. Sensory Processing

Please check those which apply:

Tactile (Touch) System	Yes	No	Comments
Become fearful with light or unexpected touch			
Complains about having hair brush, face washed, teeth brushed			
Avoid touching certain textures			
Avoid messy play (sand, water, glue, play-doh)			
Crave touch – needs to touch everything and everyone			

May not be aware that hands and face are dirty			
Enjoy and seek out messy play			
Vestibular System	Yes	No	Comments
Avoid or dislike playground equipment, elevators, or escalators			
Fearful of feet leaving the ground			
Lose balance easily/appear clumsy			
Craves fast or intense movement experiences			
Loves amusement park rides			
Frequently slumps or leans head on hand or arm			
Proprioceptive System	Yes	No	Comments
Seek out jumping, bumping, and crashing activities			
Enjoy bear hugs and roughhousing			
Frequently hit, bump, or push children			
Auditory System	Yes	No	Comments
Distracted by sounds others usually don't notice			
Avoid loud places (parades, parties, etc.)			
Does not respond to verbal cues or to name being called			
Love loud music or T.V.			
Difficulty filtering out other sounds while trying to pay attention to one person talking			
Oral Sensory System	Yes	No	Comment
Picky eater/extreme food preferences			
Gags when eating textured foods			
Licks/chews/tastes non food items			
Excessive drooling (past teething stage)			
Chews on hair, shirt, or fingers			
Olfactory System	Yes	No	Comments
Dislikes smells other people don't notice			
Nauseated by certain odors			
Fails to notice unpleasant odors			
Uses smell to interact with people or objects			

Visual System	Yes	No	Comments
Sensitive to bright lights			
Easily distracted by visual stimuli (movement, decorations, windows)			
Complains about 'seeing double'			
Fatigues easily with school work			

XIII. Educational Development

School: _____
Teacher: _____
Grade: _____
Special Services Received: _____
Child's attitude toward school: _____

XIV. In Closing

What are you hoping to gain/explore from occupational therapy services?

_____

Please note any additional concerns or related issues not addressed in this document.

_____

Who were you referred by? _____